Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 17, 2018	2018_725522_0015	009524-18	Complaint

Licensee/Titulaire de permis

The Corporation of the City of St. Thomas
545 Talbot Street ST. THOMAS ON N5P 3V7

Long-Term Care Home/Foyer de soins de longue durée

Valleyview Home
350 Burwell Road ST. THOMAS ON N5P 0A3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JULIE LAMPMAN (522)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 5, 9, and 10, 2018.

This complaint IL-56880-LO was related to the administration of pain medication.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, Registered Practical Nurses and family members.

During the course of the inspection, the inspector(s) also made resident observations, and reviewed resident clinical records and policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Pain

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident: A missing or unaccounted for controlled substance.

A complaint was submitted to the Ministry of Health and Long-Term Care regarding the administration of pain medication to a resident.

A review of administration of pain medication to three separate residents noted two identified residents had issues with the administration of a controlled substance, where the controlled substance could not be located after it was administered to the resident.

A review of one of the identified resident's clinical records noted three separate incidents where the identified resident's medication could not be located after it had been administered to the resident.

A review of another identified resident's clinical records noted eight separate incidents where the identified resident's medication could not be located after it had been administered to the resident.

A review of the home's medication incidents for a specified time period, noted three additional residents whose medication could not be located after it had been administered to the residents.

A review of LTCHomes.net critical incident system (CIS) reporting noted that the home had not submitted any critical incidents related to the above incidents of missing controlled substances.

In an interview, Director of Nursing #100 stated that the home had not submitted any CIS reports related to the missing controlled substances.

The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident: A missing or unaccounted for controlled substance. [s. 107. (3) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is informed of the following incident in the home no later than one business day after the occurrence of the incident: A missing or unaccounted for controlled substance, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A complaint was submitted to the Ministry of Health and Long-Term Care regarding the administration of pain medication to a resident.

A review of administration of pain medication to three separate residents noted two identified residents had issues with the administration of a controlled substance, where the controlled substance could not be located after it was administered to the resident.

A review of one of the identified resident's electronic progress notes noted an incident of a missing controlled substance on a specified date.

A review of the other identified resident's electronic progress notes noted an incident of a missing controlled substance on a specified date.

A review of the home's medication incident reports noted no documented evidence of a medication incident report for the above medication incidents.

In an interview, the Director of Nursing stated they were unable to locate a medication incident report related to the missing controlled substances for both residents.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

Issued on this 17th day of October, 2018

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.